

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE:	(X6) DATE:
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This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395400	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 04/03/2023
NAME OF PROVIDER OR SUPPLIER: SUSQUEHANNA HEALTH AND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 745 CHIQUES HILL ROAD COLUMBIA, PA 17512			
STATE LICENSE NUMBER: 084802					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE	
P 2020	<p>§ 211.12(i) Nursing services.</p> <p>(i) A minimum number of general nursing care hours shall be provided for each 24-hour period. The total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 2.7 hours of direct resident care for each resident.</p> <p>This REGULATION is not met as evidenced by:</p>	P 2020	<p>The facility will provide appropriate direct care staffing of 2.7 NPPD to meet the needs of the residents.</p> <p>Facility residents have the potential to be affected by this practice.</p> <p>The Administrator, Nursing Management Team and Nursing Scheduler will review the nursing schedule and deployment sheets daily to ensure RN coverage.</p> <p>The Administrator/designee will present the results of these audits at the Quality Assurance and Performance Committee monthly for further review and recommendations.</p>	<p>Completion Date: 04/21/2023 Status: APPROVED Date: 04/18/2023</p>	
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P 2020	<p>Continued from page 1</p> <p>Based upon review of staffing records and interviews with staff, it was determined that the facility failed to ensure staffing levels were above the state required minimum of 2.7 hours of direct resident care per person per day (ppd) for five days out of three weeks reviewed.</p> <p>Findings include:</p> <p>Review of staffing records for the week of March 8, through March 28, 2023, revealed the facility did not meet staffing levels on the following dates: March 10, 2023, 2.49 ppd; March 11, 2023, 2.61 ppd; March 17,2023, 2.66 ppd; March 18, 2023, 2.37 ppd; and March 26, 2023, 2.57 ppd.</p> <p>An interview with the NHA on April 3, 2023,. confirmed that the facility did not meet the 2.7 ppd hours, for these dates. .</p> <p>The facility failed to ensure that staffing levels met the minimum State regulation of 2.7 ppd hours for 5</p>	P 2020			

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Certified End Page

SUSQUEHANNA HEALTH AND WELLNESS CENTER

STATE LICENSE NUMBER: 084802

SURVEY EXIT DATE: 04/03/2023

**I Certify This Document to be a True and Correct Statement of Deficiencies and
Approved Facility Plan of Correction for the Above-Identified Facility Survey**

A handwritten signature in black ink that reads "Jeane Parisi".

Jeane Parisi
Deputy Secretary for Quality Assurance

A handwritten signature in black ink that reads "Debra L. Bogen MD".

Debra L. Bogen, MD, FAAP
Acting Secretary of Health



THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY